• FEBRUARY ISSUE | • 2007

NCA

OFFICE OF INTEGRATION NEWSLETTER

SERVING AS THE VOICE OF THE OFFICE OF INTEGRATION

in·te·gra·tion | in-ti-**grey**-sh*uh* n |

the combining and coordinating of separate parts or elements into a unified whole

MG Weightman's #1 Concern:

WR Civilian Personnel

With a steadfast commitment to keeping personnel informed about the current events surrounding the Base Realignment and Closure (BRAC) process and its impact on the integration of Walter Reed Army and National Naval Medical Centers, Maj. Gen. George W. Weightman, Walter Reed Army Medical Center commander, held a routine town hall meeting on January 16, 2007 in the hospital's Joel Auditorium. In front of a packed auditorium, MG Weightman stated that his number one concern was the civilian population.

Hoping to belay some of the growing concerns regarding the BRAC process among civilians, who make-up two-thirds of the Walter Reed workforce, the commanding general offered updated news pertaining to the governance of Walter Reed National Military Medical Center (WRNMMC) at Bethesda, the suggested manpower shifts between the new, robust hospital at Fort Belvoir and WRNMMC, and the introduction of various displaced employee programs.

MG Weightman restated some of the points given during the town hall meeting held on November 6, 2006 and much of the update focused on the issues of command and control for WRNMMC. Recent news from Health Affairs states that the commanding governance of the tri-service facility will be available to all Services, giving it to the best qualified. While this decision is not a final one, it will likely appeal to the other services, as the new WRNMMC will serve as the gravity of military medicine world-wide.

In MG Weightman's briefing, he stated that the BRAC recommendations suggest that slightly less than 2,100 military and civilian authorizations should be realigned with the new hospital at Fort Belvoir and approximately 800 will be realigned with WRNMMC. The audience was also informed that A-76 process is inclusive of those numbers.

Key members of his Civilian Personnel Advisory Center (CPAC) listened close by as MG Weightman introduced various programs that will likely be used to assist Walter Reed civilian employees with their transition. These included Voluntary Early Retirement Authority (VERA), Department of Defense (DoD) Priority Placement Program, Interagency Career Transition Assistance Plan (ICTAP), and Department of Labor One Stop Career Centers, among others.

Attendees, military and civilian alike, were challenged by the two-star general to seize the opportunity to "shape WRNMMC into a premier, world-class healthcare facility, the only of its kind." He reiterated his conviction that the new governance decisions will assist in achieving just that. ■

INSIDE THIS ISSUE:

What's Going On? (Parts II & III)

An Inside Look at Integration

Last month we were invited to sit down with CAPT David Wade, Chief of Staff for the MSMO and Director of the Integration Steering Committee (ISC), to have a candid discussion on his perspective of the current, evolving events surrounding the integration of Walter Reed Army Medical Center (WRAMC) and National Naval Medical Center (NNMC).

Due to the length of our discussion, this interview was originally divided into three parts. Last month we featured part one. However, we've decided to feature both parts two and three this month.

OOIN: In the beginning stages of the integration planning, the Flags chose an approach that extended authority to key stakeholders at each institution with the opportunity to frame the path by which integration would be achieved.

What would you say has changed since the reorganization, which introduced Deputy Commanders for Integration at both Walter Reed and Bethesda coupled with the Commanders Executive Board (CEB) taking a more involved role, all of which reflects a more traditional approach?

DW: While some people may view activities in the months of November and December of last year as a demonstration of leadership's lack of confidence in the integration effort to date, I do not. I feel like it reflects the natural progression of what we are trying to do with integration. When we started this process in the late summer of 2005, it was very difficult to wrap our arms around how we were going to approach the tasks of integration. When it started there were no immediately available answers, no operational procedures or a "how-to" book to turn to. Therefore, Flag Leadership asked a group of leaders in our medical centers to get started and they expected that we would figure it out as we went along. And that's exactly what happened.

At the same time that they told us to attack this "world hunger" sort of integration problem. They also said there was a timeline we needed to meet, that there is a sense of urgency to our integration efforts. There was a charge from Flag leadership to stand up the Integration Steering Committee (ISC) and move out smartly. We were told we'd have 12 – 18 months to complete this task. That clearly was a stretch goal. Now it's been about 18 months since we started that effort and we've done a lot of work. We did a lot of trust building between individuals, a lot of relationship building between institutions, and developed many processes. We also got a better handle on what steps we need to complete to make integration a success. While we haven't quite made all the progress we had hoped for, we now have a much better idea of what we need to do and when to do it. Now is the time to not only advance integration from the bottom of the ranks through to senior leadership, but to also begin to prioritize some of those efforts from senior leadership back down through the ranks.

In the past year, we've seen the establishment of the Deputy Commanders for Integration at NNMC and WRAMC (COL West and CAPT Damiano, respectively). Now they are very much part of providing input to the ISC and the Office of Integration by helping us set priorities for integration. As a part of that experience, we're now writing an integration plan that speaks to project timelines. The plan specifically moves from an operational level to a tactical level. Working at a tactical level allows us to accomplish the myriad of tasks necessary to have integration become a reality. It is this type of activity that will be the focus of the ISC in the coming year. This integration plan will be a living document that changes as we get smarter about how to do things and will become a robust, "how-to" book that guides us as we move forward with this historical effort.

OOIN: In December's newsletter, Dr. Schinski, from USU, offered our readers an inside look at the reorganization of the decision making process within the NCA regarding integration.

Why did senior leadership choose to shift the focus from the entire NCA healthcare delivery system to focusing primarily on Walter Reed and National Naval?

DW: Early on, our Flag leadership recognized that integrating tertiary care was the critical lynchpin of our efforts. When you look at our NCA healthcare delivery system, it runs the gamut from primary care clinics (i.e., Pax River) to small, inpatient MTFs (i.e., DeWitt) to ambulatory surgery centers (i.e., Kimbrough) to the medical centers (i.e., Walter Reed and Bethesda). It's always been the top priority of the Flag leadership that the immediate task of integration is to get the most complex part of system (i.e., the tertiary care part) done correctly. If we develop an integrated healthcare delivery system that involves the smaller MTFs working in a coordinated fashion, but neglect making Walter Reed and Bethesda do that very hard work of becoming functionally integrated, we will fail in our efforts.

(See Page 3)

What's Going On? (Parts II & III)

An Inside Look at Integration (continued)

(continued from page 2)

DW: If we don't get the MEDCENs right, then most of the other efforts will be wasted. So that is why in the months of November and December the Flags said, "We've gotten a little bit off course from where we need to be and we must concentrate on making the medical center integration work first and then we'll deal with more of the broader, market-wide concerns."

OOIN: In the next 12-18 months what do you see as the necessary level of involvement for those non-medical center MTFs?

DW: It runs the spectrum of intense involvement that is very personal on the part of the Medical Center leadership to, "Gee, that's nice to know" on the part of some of our smaller, more outlying MTFs. All of our market MTFs have a role to play, however, there will always be tension between market-wide concerns and what is a medical center focused area. On some issues, specific commanders may feel that integration is very much their business, while on other topics they may feel it really isn't. There will always be that sort of tension, but if all of those commanders have situational awareness about what's going on, they will have better trust and faith that the integration leaders and the ISC are appropriately addressing issues that will eventually affect them. I think that is how this will play out.

OOIN: How about in the next 30 days?

DW: It would be those upfront targets that Colonel Bill Doukas, the first chief of the newly WRAMC/NNMC integrated Orthopedics & Rehabilitation department needs to deal with. How do I access departmental budgets at both WRAMC and NNMC ? How do I move departmental money between the MEDCENS? How do I move equipment between MEDCENS? How do I move my people around to best deliver the benefit between Walter Reed and Bethesda? How do I do TAD for Army and Navy staff? How do I complete FITREPs and OERs for my Army and Navy staff? Those are the upfront targets he needs to be able to do, so those items are the 30-day targets.

OOIN: How about in the next 180 days?

DW: What we're looking to accomplish is the fleshing out of the "how-to" book for other departments and clinical services that will be integrating. Some of these items are 1.) How to do we make equipment purchases for the upcoming year? 2.) How do we ensure we're Joint Commission compliant for an integrated department? We must ensure that we keep ourselves within statutory or regulatory requirements of our accrediting agencies. These are some of the things to be accomplished within the next 180 days.

OOIN: How about in the next year?

DW: Realistically a year from now, ISC will hopefully be at a point where they will be ready to swing focus to some market-level activities. A year from now we'll be starting construction, or very close to starting construction, over on the Bethesda campus and they'll likely have started already down at Ft. Belvoir. At Bethesda, there will be the need to accommodate construction and still continue the clinical care delivery activities. That may involve moving not only patients over to WRAMC, but also staff from Bethesda to work at WRAMC. We have an impressive schedule laid out for clinical integration during the course of the next year. It is my hope and belief that at the end of calendar year 2007 people at both WRAMC and NNMC will feel, "Gosh, we're really integrated". ■

The Road Traveled: 2006 Integration Achievements

Implemented a successful Integration pilot program in the Department of Dermatology

Chief chosen for the WRAMC/NNMC integrated Orthopaedics and Rehabilitation Department

Developed a quality dashboard of clinical metrics to examine the quality of care across institutions

Established one BRAC/Integration Public Website

One common set of business rules were approved and adopted for Healthcare Operations NCA-wide

Developed a coordinated process for public affairs press announcements to be developed and disseminated

Created first monthly NCA Office of Integration Newsletter

Developed plan to migrate to one integrated NCA newtwork and doman (nca.mil)

FEATURE SPOTLIGHT

Ms. Dawn Marvin–
Department Head, Marketing & Communications
Integration Communication Committee (ICC) Chair
National Naval Medical Center (NNMC)

ICC AREA OF FOCUS:
The committee's task is to develop and execute an overall marketing communications plan for the realignment of WRAMC, NNMC, and DeWitt Army Community Hospital in accordance with the 2005 Base Realignment and Closure (BRAC) law.

What Will Our Emblem Look Like?

As we work together to create the new and exciting future world we will know as Walter Reed National Military Medical Center (WRNMMC) at Bethesda, it will be imperative that we create and wisely use a coordinated branding image (emblem) to positively represent WRNMMC throughout the world. As more and more clinics integrate, clinic personnel are enthusiastic and excited about their "new" role as an integrated WRAMC/NNMC clinic. Although there is positive work being done to create what WRNMMC will become in the future, it's not yet time to publicly release a branding image (or emblem), nor is it time to publicly use the WRNMMC name. We need to be mindful of the effects of releasing our future emblem or name prematurely.

"An image is not simply a trademark, a design, a slogan or an easily remembered picture. It is a studiously crafted personality profile of an individual, institution, corporation, product, or service.
—Daniel J. Boorstin

A branding image or name used too soon, before we are actually merged under one leader or roof, may confuse our staff, beneficiaries and the general public. It is also too soon for an emblem to be used by newly integrated clinics or departments. The good news is that we may be able to use a common emblem as early as the summer of 2008, the time when leadership projects that we will be totally functionally integrated and at that time a "joint Commander" of the two facilities may be named. Another reason for this seemingly conservative approach is that The Joint Commission considers the publication of a "common" emblem as a signal to the community, our staff, and beneficiaries that we (WRAMC and NNMC) are now one entity, and although we are making steps daily to work toward that goal, we are not yet one entity.

And lastly, and perhaps most important is that we want to do this right– not creating an emblem too quickly, but taking the time for all the steps required to produce a professional emblem.

The choice and design of these images, their accompanying text and the way they are used is serious business and take into consideration many elements and disciplines, both obvious and some not so obvious. Ultimately the goal of the branding campaign is to represent the organization and what it stands for.

(See Page 5)

INTEGRATION COMMUNICATIONS COMMITTEE (ICC)

NAME:	AFFILIATION:
MR. STEPHEN SANDERSON	WALTER REED ARMY MEDICAL CENTER (WRAMC)
MS. PATRICIA CASSIMATIS	WALTER REED ARMY MEDICAL CENTER (WRAMC)
MR. BRIAN BADURA	NATIONAL NAVAL MEDICAL CENTER (NNMC)
MS. DAWN MARVIN	NATIONAL NAVAL MEDICAL CENTER (NNMC)
MS. KAREN STANSBURY	NATIONAL NAVAL MEDICAL CENTER (NNMC)
MS. SHARON WILLIS	UNIFORMED SERVICES UNIVERSITY (USU)
MS. LADONNA BOWEN	79th MEDICAL WING/MGMC
MS. JAN CLARK	DEWITT ARMY COMMUNITY HOSPITAL (DACH)
CAPT KATHLEEN PIERCE	OFFICE OF INTEGRATION (OI)
MS. SHONDELL TOWNS	MULTI-SERVICE MARKET OFFICE/OI

What Will Our Emblem Look Like?

(continued from page 4)

To successfully accomplish this a visual communication's professional works with a team of researchers, creative writers, graphic designers and sometimes photographers.

In following issues of this newsletter, we will update you on the process and progress of the image branding/emblem campaign and address such issues as:

- How do we ensure that the branding image represents WRNMMC's Vision?
- What is *iconology* and how will we use this field of study?
- What is the Institute of Heraldry, and how will they assist in the creation and research for or emblem?
- How are subliminal elements and elements of design used in the creation of an emblem?
- What is a logo "steward" and what is a logo "style book?"
- How will focus groups be used to help us decide on the final product?

What will be described to you in a series of articles can take from 6 to 12 months. We are starting this process now so that we will be ready to launch a new WRNMMC emblem by the Summer of 2008. ■

THE US FLAG-
A Historical Account of the
The Most Widely Recognized Symbol

July 4, 1776
At the time the Declaration of Independence was signed, the Continental Colors flag was flown

1777
The United States adopted the Stars and Stripes, where the flag consisted of 13 red and white stripes with the original British Union Jack in the canton

June 14, 1777
The Second Continental Congress passed the Flag Resolution which stated: "Resolved, That the Flag of the United Stated be thirteen stripes, alternate red and white; the union be thirteen stars, white in a blue field, representing the Constellation

1795
The number of stars and stripes was increased from 13 to 15 to reflect the entry of Vermont and Kentucky as states of the union

1818
A plan was passed by Congress at the suggestion of the U.S. Naval Captain, Samuel C. Reid in which the flag was changed to have 20 stars, and a new star would be added when each new state was admitted, but the number of stripes would remain at the 13 to honor the original colonies

The Flag Act of April 4, 1818 was passed stating that the flag design changes will occur only on July 4th, as it commemorates the founding of the nation.

1912
Until the Executive Order of June 14, 1912, neither the order of the stars nor the proportions of the flag was prescribed, so consequently flags dating before this time sometimes showed unusual arrangements

Straight rows and stars that are represented in the U.S. Flag today were officially adopted

1960
The flag changed from 49 stars to 50 to include Hawaii's statehood in August 1959

***Sources:**
Wikipedia and USFlag.org

Gripes Into Go-Bys

By: Dr. Vern Schinski
Vice President for BRAC Integration
Uniformed Services University of the Health Sciences (USU)

It seems to be part of our culture to gripe about the system – it is almost a Soldier's, Sailor's and Airman's right. Maybe we've seen too many war movies, or maybe our system is so complex that there is always room for improvement. However, it seems that if you sit down with colleagues for a cup of coffee, or lunch, or arrive early for a meeting, someone will soon be expressing frustration with how the system does not work.

I believe that integration is our chance to do something about the system – to leave it better than we found it. Early in our process Major General Farmer, former commander of Walter Reed, expressed the thought that Integration was "*the right thing to do, if we do it right.*" These thoughts were translated into our vision and our approach. Not only did we have a vision of creating a model academic health center for military medicine, we were given an opportunity that challenged us to select the best of the Army, Navy, and Air Force systems. We were encouraged to add our best ideas, and create our most inventive methods such that the whole would be clearly better than the sum of it's parts.

THE VISION

We envision and are committed to one integrated health system which leverages the assets of all DoD health care treatment facilities in the National Capital Area (NCA). The tri-service Walter Reed National Military Medical Center at Bethesda will be a worldwide military referral center and together with the Uniformed Services University of the Health Sciences (USU) will represent the core of this integrated health system. All tri-service facilities in the NCA and USU will serve as a premier academic medical system focused on delivering the highest quality care, distinguished health professional education, and exemplary clinical and translational research.

I believe that little has changed. Everyone always knew that resources and regulations would provide outer limits to our creativity. Admiral Robinson gave the advice to "*proceed until apprehended.*" While questions of Command and Control and decisions about which regulations we had to follow and which we could re-write, soon entered the picture, we were continually encouraged by leadership to proceed.

Groups of individuals with similar responsibilities at multiple levels of our healthcare delivery system came together in committees, subcommittees, and working groups to look at the future. The universal first reaction seemed to be that there was no way we could make this happen. However, after sharing our differences we began to discover similarities. Soon common goals and means were identified as areas for sharing and integration – and the process grew and grew. Teams representing the two medical centers, the other bedded facilities, and the university began documenting common standards, common methods, and joint planning for the future. Within months the commanders of the remaining medical treatment facilities in the National Capital Area (NCA) were engaged in the planning process.

While Congress, the Department of Defense, and the Surgeons General struggled to determine the size and shape of a Unified Medical Command, our teams continued to develop new models from the best of the services and the creative ideas of our people and the broader healthcare community. A construction budget for the North (WRNMMC at Bethesda) and South (Fort Belvoir) campuses was assembled, defended, and approved. A host of specialty teams built space requirements based on BRAC data and new concepts of operation that were sent to the architects on 1 February. Integration subcommittees developed goals and objectives for 2006, which were approved by the Flag Officer oversight group, and to a great extent accomplished as planned. Professional and administrative groups of all kinds identified, and documented for approval, many common standards, methods, and operational goals. The Air Force committed to contributing additional healthcare manpower to the NCA. Position descriptions and selection criteria for medical center clinical leadership appointments were written and approved. To date, only one selection has been finalized and announced (the Department Head of WRAMC/NNMC integrated Orthopedics), many are underway, and all major clinical positions are scheduled for selection by summer 2007. Now, new more specific goals are being developed for completion in 2007. We are finding ways to make the hard choices that will create a model for military medicine.

Because BRAC has the weight of law, we will have jointly-staffed hospitals at Bethesda and Fort Belvoir. Because you and your colleagues have been involved, it will be better than the sum of its parts and will begin to serve as a test-bed for all of military medicine. Simply said, this is our opportunity to leave a legacy to future generations by making the MHS better than it is currently. ■

The Organizational Development Practitioner's Information Corner

Each month we will feature an article from our Organizational Development Practitioners (ODPs). Through the "ODP Information Corner", they'll assist us with better understanding the human behavioral dynamics associated with the organizational changes we are experiencing. We have ODPs working very closely with change leaders at various levels at each of the nine military treatment facilities within the National Capital Area (NCA).

Organizational Development:
What is it?

By: Patrick Sanderson, CDR, USN, PhD, FACHE

Various theorists have provided their definition of Organizational Development (OD). French and Bell (1978) emphasize the application of behavioral science in defining the practice of OD, stating "Organizational Development is a long-range effort to improve and organization's problem-solving and renewal processes…through the management of organization's culture and the use of the theory and technology of applied behavioral science". They further stated "that it ties individual events together into a coherent, directional thrust". The one common word in all definitions is "change". The most accepted definition of OD is presented by Dr. Michael Broom, who summarized the practice as supporting organizational leaders and their groups to create long-lasting, systemic change by improving the human processes by which they accomplish their tasks or get things done.

> **Organizational Development** is defined as the collaboration with organizational leaders and their groups to create systemic change and root-cause problem solving on behalf of improving productivity and employee satisfaction through improving the human processes through which they get their work done.
>
> **Michael F. Broom, Ph.D**

The OD Practitioner does not own the work that is being done. The ownership belongs to the client/leader (Director, department head/service Chief, Commander/Commanding Officer, Deputy/Executive Officer, etc.). The OD Practitioner develops and owns the processes that support the client/leader. For example, the OD Practitioner will develop processes that help the client/leader enhance the effectiveness of his/her team to execute the desired change efforts. Similarly, the OD Practitioner will develop processes to help the team leader build an effective strategic plan to guide the functioning of the organization. Additionally, the Practitioner will devise methods that unravel suppressed matters and re-channel those matters into cooperative efforts. They help work problems through to successful resolution and draw individuals or groups together into functional teams

Some components of OD include:

1. Team Building
2. Change leadership/ management
3. Strategic planning
4. Systems thinking
5. Process Improvement/ management
6. Facilitation
7. Conflict management/ mediation
8. Whole-scale intervention (i.e., integration efforts)

Some of the basic techniques used in executing an OD activity include:

A diagnosis of the organization's situation/issue/ concerns. This is done through data gathering (interviews or observation, etc.). The data is used as a discussion and feedback mechanism that is then analyzed to help design the best approach or process to accomplish the desired outcome.

Action. Take those steps that are necessary to meet desired results. ■

Reference:

French, W. L and Bell, Jr. C. H. (1978). Organizational Development: Behavioral Science Interventions for Organization Improvement. Englewood Cliffs, NJ, Prentice-Hall, Inc.

Are You Acronym Crazy?

Don't worry, we want to provide some clarity.

In a culture where acronyms are commonly used, new events such as the Base Realignment and Closure (BRAC) recommendations being made law by Congress, brings into existence more acronyms that typically make communicating in a culture like ours a little crazy.

Here we try to make sense of it all for you. Brace yourself, because a few of these may surprise you. This month you'll find meanings to some commonly used acronyms. ■

(D(PA&E))– Director, Program Analysis and Evaluation
Definition:
Bradley M. Berkson

EA– Enterprise Architecture
Definition:
A blueprint of how an organization does business and how IT systems enable the business

EBM– Evidence Base Medicine
Definition:
an uniform application of the standards of evidence gained from the scientific method, to certain aspects of medical practice

FIAR– Financial Improvement and Audit Readiness
Definition:
A directorate of the Office of the Under Secretary of Defense (Comptroller) that manages DoD-wide financial improvement efforts and integrating those efforts with transformation activities across the Department

FY– Fiscal Year
Definition:
A 12-month period that begins on October 1st and ends on September 30th

GME– Graduate Medical Education
Definition:
The time required by a physician to meet the educational requirements for certification by an American specialty board

GOCO– Gov't Owned Contractor Operated
Definition:
A partnership that allows each partner to perform duties for which it is uniquely suited: the government establishes mission areas, and the private sector implements the missions, using best business practices

GWOT– Global War on Terrorism
Definition:
The official name given by the United States of America and some of its allies to describe the U.S. military operational campaign designed to fight terrorism in the wake of the September 11, 2001 attacks

IEC–Infrastructure Executive Council
Definition:
A senior group established by the Secretary of Defense to oversee and operate the BRAC 2005 process, which is chaired by the Deputy Secretary of Defense, and is comprised of the Secretaries of the Military Departments and their Chiefs of Services, the Chairman of the Joint Chiefs of Staff and Under Secretary of Defense (Acquisition, Technology and Logistics)(USD (AT&L)) for policy making and senior executive oversight body for the entire BRAC 2005 process

ISC– Integration Steering Committee
Definition:
A group of senior leaders representing Walter Reed Army Medical Center, National Naval Medical Center, Dewitt Army Community Hospital, and Malcolm Grow Medical Center in 8 functional areas: Clinical Services, Nursing, Healthcare Operations, Research, Professional Education, IM/IT, Administrative Services, and Marketing & Communications; whose primary objective it is to execute the tactical means by which integration will be achieved in the NCA MHS

ISG– Infrastructure Steering Group
Definition:
The subordinate of two senior groups established by the Secretary of Defense to oversee and operate the BRAC 2005 process, which is chaired by the Under Secretary of Defense (Acquisition, Technology and Logistics) (USD (AT&L)), and is comprised of the Vice Chairman of the Joint Chiefs of Staff, the Military Department Assistant Secretaries for installations and environment, the Service Vice Chiefs, and the Deputy Under Secretary of Defense (Installations & Environment) (DUSD(I&E)) with responsibility of overseeing the joint cross-service analyses of common business-oriented functions to ensure the integration of that process with the Military Department and Defense Agency

RUMOR CONTROL: SO TRUE OR SO FALSE ???

SO FALSE

WRNMMC will be governed by only the Navy

SO TRUE

MG Weightman's #1 concern are civilian personnel

SO FALSE

Organizational Development is just a "touchy-feely" process for team-building

SO TRUE

Organizational Development serves as the lynchpin for change within an organization

SO FALSE

COL West, Deputy Commander for Integration at NNMC, represents WRAMC at NNMC

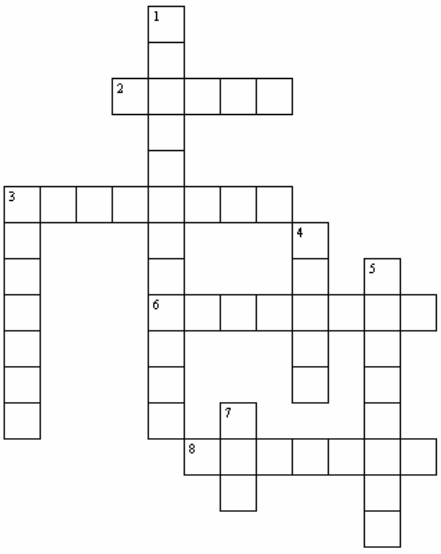
Our Mission:

Force Health Protection

To meet and adapt to the evolving health care needs of our military force, our mission, as established by the Department of Defense, is to use preventive health techniques and emerging technologies in environmental surveillance and combat medicine to protect all service members before, during, and after deployment.

Force Health Protection is designed to improve the health of service members, prepare them for deployment, prevent casualties, and promptly treat injuries or illnesses that do occur, as well as care for their family members, and retirees and their families, who have served this great nation.

TRI-SERVICE CROSSWORD PUZZLE



ACROSS

2 Air Force Term: A name for anyone in aviation
3 Navy Term: Canvas white hate worn by sailors
6 Army Term: Son or daughter of career soldier
8 Army Term: Full Bird

DOWN

1 Navy Term: Dress blue uniform for E-6 and below
3 Army Term: Operator's Manual for Equipment
4 Navy Term: Affectionate term for someone who does what you do
5 Air Force Term: Hangar deck of an aircraft carrier
7 Air Force Term: Mission or flight

ANSWERS FROM LAST MONTH:

ACROSS	DOWN
2 Nuke 4 Air Bear 6 Five and Fly 7 Cammies 8 Captain's Mast 9 Grunt	1 Dead Man Walking 3 MRE 5 Bird

National Capital Area Military Health System

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THE FUTURE OF THE NCA MHS

Our Vision

We envision and are committed to *one* integrated health system which leverages the assets of all DoD health care treatment facilities in the National Capital Area.

The Tri-Service Walter Reed National Military Medical Center at Bethesda will be a world-wide military referral center and together with the Uniformed Services University of the Health Sciences (USU), will represent the core of this integrated health system.

All Tri-Service facilities in the NCA and the USU will serve as a premier academic medical system focused on delivering the highest quality care, distinguished health professional education, and exemplary clinical and translational research.